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GLOBAL RESEARCH BRIEF

PSP-One

LAPM Brief 2

Expanding Access to Contraception: How Ability to Pay Affects Use and Source of IUDs

BACKGROUND

Greater use of long-acting and permanent methods (LAPMs) of contraception – intrauterine devices (IUD), implants, and sterilization – has the potential to increase continuation rates and reduce unintended pregnancies. In the past few years, efforts to revitalize IUD use have intensified. IUDs are highly effective and can be used for up to 10–12 years, but can also be quickly reversed with fertility returning swiftly once the device is removed.

Greater use of the IUD would be more affordable than other methods for countries planning for the phase-out of donor-provided contraceptive commodities. Its commodity cost per couple year of protection is only $0.58.[1] Equivalent protection from injectables, assuming they are used for the same average time period as an IUD (3.5 years), would cost almost $14. Clearly an increase in the use of IUDs combined with a decrease in the use of injectables would reduce the financial burden on ministries of health. However, in many developing countries, the opposite is occurring – injectable use is rising, IUD use falling.

In addition, public sector resources for contraception should be focused on the two lower (poorer) wealth quintiles. Appropriate market segmentation would show households in the wealthiest three quintiles – which have higher ability to pay – using the private commercial (for-profit) sector and poorest households relying primarily on not-for-profit nongovernmental organizations (NGOs) and the public sector.

While several papers have examined targeting and market segmentation as strategies to achieve contraceptive security, they contrast the public and private sectors without differentiating between for- and not-for-profit components of the private sector.[2] One reason for this is lack of data that disaggregates the private sector into for- and not-for-profit.[3] This brief looks at where women get their IUDs and how source varies with ability to pay. Because NGOs generally subsidize services, this analysis disaggregates the private sector into its commercial and NGO components.

RESEARCH

Discussion in this brief of IUD use and source by ability to pay is based on Demographic and Health Survey country data that (a) show IUD use prevalence among women in union is at least 9 percent, (b) divide the private sector into commercial and non-commercial, and (c) categorize women according to their wealth. This excludes countries for which source was divided only into public and private and where almost all IUDs were obtained in the public sector, common in countries of Western Asia and Eastern Europe.

FINDINGS

Four countries (Colombia, Peru, Bolivia, Egypt) met the inclusion criteria for this analysis. The percentage of women using IUDs is highest in Egypt (see Figure 1, page 2). While the percentage of women using IUDs increases steadily with wealth in Peru, Bolivia, and Egypt, in Colombia, IUD use prevalence is 8-9 percent in the two lowest quintiles, then jumps to 15-16 percent in the two middle quintiles and falls to 13 percent in the highest quintile.

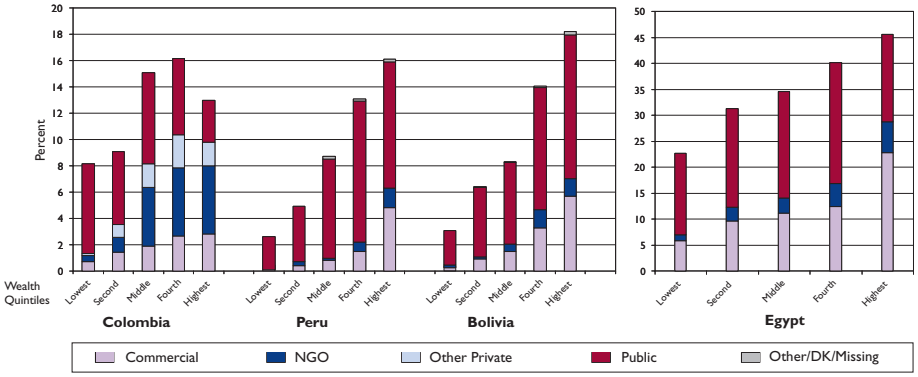
The public sector is the dominant provider of IUDs in all four countries. The commercial sector is the second most important provider except in Colombia, where NGOs play a prominent role. In all four countries, not surprisingly, the percentage of women getting IUDs

[1] Weighted average. Prices here are U.S. Agency for International Development (USAID) and United Nations Population Fund prices in Ross J., Stover J., Adelaja D. (2005). *Profiles for Family Planning and Reproductive Health Programs: 116 countries*" 2nd ed. Glastonbury, CT: Futures Group; and calculated from International Drug Price Indicator Guide, Management Sciences for Health, **http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=DMP&language=English**

[2] Sine, J. (2003). *Policy Issues in Planning & Finance.* No. 3, Oct 2003. Washington, DC: POLICY Project; Sharma, S., Gribble, J.N., Menotti, E.P. (2005) *Creating options in family planning for the private sector in Latin America.* Rev Panam Salud Publica/Pan American Journal of Public Health 18(1):37–44.

[3] Janowitz, B., Gmach, R., Otterness, C. (2006). *The Commercial Sector's Role in Providing Long-Acting and Permanent Methods.* Bethesda, MD: Private Sector Partnerships-*One* project, Abt Associates Inc.

Figure 1: Percentage of in-union women obtaining IUDs from various sources, by wealth quintile



Notes: Differences in scales are used on the Y-axis; using the same scale for all four countries caused a loss of detail in Colombia, Peru, and Bolivia. Colombia's "other private" refers to Cajas de Compensación Familiar, part of the Social Security system but classified by various publications as private or NGO.

from the commercial sector increases with wealth. However, only in Egypt does the commercial sector provide more than half of the IUDs to women in the highest wealth quintile.

The contribution of the public sector to IUD provision generally increases with wealth. For example, in Egypt about 16 percent of women in the lowest wealth quintile get IUDs in the public sector compared with 24 percent in the second highest wealth quintile (although the very wealthiest women substantially increase their use of the commercial sector and decrease use of the public sector). Of course, while a higher proportion of IUD users in the lowest wealth quintile compared to the second highest quintile get their IUDs in the public sector, more women get their IUDs in the public sector because IUD use increases with wealth.

The contribution of NGOs generally increases with wealth status as well. For example, in Colombia, NGOs provide more than three times as many IUDs to women in the highest wealth quintile as they do to women in the second lowest quintile. In Egypt, NGOs provide more than five times as many IUDs to women in the highest quintile as they do to women in the lowest quintile. Thus, NGOs are not primarily serving clients with the lowest ability to pay.

POLICY IMPLICATIONS

Although the commercial sector's contribution to the provision of IUDs increases with the client's wealth, it is the dominant provider of IUDs to women in the highest wealth quintile in only one of the four countries studied (Egypt). The public sector and NGOs remain important providers even among women who can best afford to use the commercial sector. These women are apparently unwilling to spend their money to avoid the inconvenience of the public sector, or they may find the modest fees charged by NGOs reasonable. Moreover, donor funds have likely facilitated the improvement of quality of care at NGOs with the result that women are more satisfied with the services. As a consequence, women may not be convinced that services in the commercial sector are of sufficient quality to be worth the extra cost. (Please refer to Figure 1 in LAPM brief 3, "Expanding Access to Contraception: IUD Fees and Subsidies in Egypt.")

This analysis of how use of the commercial sector varies with wealth covers only four selected countries; we do not know if the same pattern holds true in other countries that have a high prevalence of IUDs. Research indicates that in Latin America and the Caribbean a significant proportion of users in the two highest wealth quintiles gets contraceptives from the public sector and not from the private sector; however, the report does not break down the private source into commercial and NGO sectors.[4] It would not be surprising to find high use of the public sector for IUD users in a greater number of countries, irrespective of wealth. Analysis of data from a larger number of countries, including from surveys of the Centers for Disease Control and Prevention, would allow a more complete analysis of how wealth affects use and source of IUDs. Findings could be used to design programs to encourage IUD use in the commercial sector for those who can afford such services.

[4] Taylor, P.A., Quesdad, N., Abramson, W., Dayaratna, V., Parykewich, L. (2004) *Regional Report: Contraceptive Security in Latin America and the Caribbean. Results and Recommendations.* [Electronic version]. Arlington, VA: DELIVER Project, John Snow, Inc. and Washington, DC: POLICY II, Futures Group for the United States Agency for International Development (USAID).

About PSP-*One*

The PSP-*One* project is USAID's flagship project, funded under Contract No. GPO-I-00-04-00007-00, to increase the private sector's provision of high-quality reproductive health and family planning (RH/FP) and other health products and services in developing countries. PSP-*One* is led by Abt Associates Inc. and implemented in collaboration with eight partners:

Banyan Global
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